Department of Veterans Affairs **M-2, Part V**
Veterans Health Services and
Research Administration
Washington, DC 20420 **July 13, 1989**

1. Transmitted is a revision to Veterans Health Services and Research Administration Manual M-2, "Clinical Affairs," Part V, "Nursing Service." Brackets have not been used to indicate changes.

2. Principal change:

Paragraph 6.04. Updated to delete subparagraph b.

3. **Filing Instructions**

Remove pages	**Insert pages**
Cover page through v	Cover page through v
1-1 through 6-1	1-1 through 6-1
A-1 through A-16	A-1 through A-17

4. **RESCISSIONS:** M-2, part V, dated April 1, 1985; M-2, part V, change 1, dated January 15, 1987.

JOHN A. GRONVALL, M.D.
Chief Medical Director

Distribution: RPC: 1028
FD

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DEPARTMENT OF
VETERANS AFFAIRS

CLINICAL AFFAIRS
Nursing Service

July 13, 1989

Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC 20420

Part V, "Nursing Service," Veterans Health Services and Research Administration Manual M-2, "Clinical Affairs," is published for the compliance of all concerned.

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RESCISSIONS

The following material is rescinded:

COMPLETE RESCISSIONS

a. **Manual**

M-2, Part V, dated September 15, 1955.
M-2, Part V, dated April 22, 1963, and changes 1 through 5.
M-2, Part V, dated April 21, 1975.

b. **Interim Issues**

II 10-67-38
II 10-71-32
II 10-76-9

c. **Circulars**

10-84-24
10-84-103
10-85-82
10-85-164
10-88-148

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CHAPTER 1. ADMINISTRATION OF NURSING SERVICE

1.01 STATEMENT OF POLICY

The VA Nursing Service provides care that will assist veterans in maintaining or regaining health, learning to live with disabilities, or dying with dignity and comfort. Nursing Service accomplishes this mission through humanistic and outcome oriented programs which ensure effective patient care and provide nursing personnel with opportunities for professional growth. Nursing is a clinical practice discipline, which is supported by programs in administration, education and research.

1.02 GENERAL PROVISIONS

a. The Chief, Nursing Service, will contribute to medical center policy development, planning, decision making, resource management and evaluation that affect the delivery of health care services to patients.

b. The Chief, Nursing Service, will contribute to the medical center's budget by forecasting resource requirements of the nursing program, including personnel.

c. The Chief, Nursing Service will contribute to the strategic management process of the medical center.

d. The Chief, Nursing Service, will participate in planning for new construction, renovating facilities and selecting equipment to be used by nursing personnel.

e. The Chief, Nursing Service, will develop, administer and evaluate a comprehensive program which meets the nursing care requirements of patients, within the policies and guidelines of the VHS&RA (Veterans Health Services and Research Administration) and the Department.

f. Programs in nursing administration, education and research will be established to promote excellence in clinical practice. These programs will include the evaluation and implementation of new developments in nursing practice; the enhancement of nursing knowledge through education, the clinical application of new knowledge and contributions to professional literature; and the promotion of research directed toward the improvement of nursing practice.

g. Nursing Service philosophy, standards, goals and objectives will be defined. These will be developed in collaboration with nursing personnel responsible for their implementation. Nursing Service programs will be evaluated periodically to ensure their effectiveness in meeting accepted standards, goals, and objectives.

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h. Organizational and functional charts for Nursing Service will delineate authority and responsibility.

i. Standards applicable to Nursing Services will be met.

j. The medical center director and chief of staff will be informed of Nursing Service accomplishments, problems and recommendations.

k. The Chief, Nursing Service will meet regularly with nursing personnel on all tours of duty. Minutes of meetings will be maintained and distributed as appropriate.

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l. Nursing Service committees will be established to assist in attaining goals. Purposes and functions of each committee will be published, and minutes of meetings will be maintained and distributed as appropriate. Nursing Service will be represented on multidisciplinary committees to enhance the delivery of health care.

m. The Chief, Nursing Service, will ensure collaboration and sharing with appropriate professional and health care organizations in the community to enhance nursing care and staff development programs. This will be done in accordance with VA policies and guidelines.

1.03 PERSONNEL

a. The Chief, Nursing Service, will be responsible for the selection, orientation, assignment, and appropriate utilization of Nursing Service personnel. Nursing staff assignments will be congruent with patient care needs and employee qualifications.

b. The Chief, Nursing Service, or designee will use professional judgment and expertise in interpreting policies and developing programs that ensure competent nursing practice and fair personnel practices.

c. Registered nurses will be responsible for all nursing care. This will include the direct supervision of all categories of nursing personnel and nursing students providing care to patients.

d. Recruitment and retention programs will be established to meet local and agency requirements for qualified nursing personnel. The Chief, Nursing Service will identify qualified applicants and candidates for centralized positions and training programs to Central Office Nursing Service.

e. Career development programs will be established. Opportunities will be provided for nursing personnel to perform at increasing levels of competence as appropriate.

f. Functional statements or position descriptions will be developed for nursing personnel as appropriate. These will be reviewed annually and revised as necessary.

g. A Nurse Professional Standards Board will be established in accordance with VA policy.

h. Supervisory nursing personnel will comply with the terms of negotiated union agreements.

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i. Patient care support functions will be examined for possible realignment. The Chief, Nursing Service will collaborate with medical center program managers to ensure the effective utilization of nursing personnel to provide direct clinical care to patients.

1.04 VOLUNTEERS

a. Volunteers assigned to Nursing Service will function according to guidelines established by Nursing Service and Voluntary Service.

b. There will be a designated coordinator for volunteer programs in Nursing Service. The activities of volunteers participating in patient care programs will be supervised by a registered nurse. Orientation and training programs for volunteers will be provided.

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CHAPTER 2. CLINICAL NURSING PRACTICE

2.01 STATEMENT OF POLICY

All registered nurses are responsible and accountable for the nursing care of patients, and for maintaining high standards of nursing practice and professional conduct. Nursing practice contributes to the promotion and maintenance of health, the prevention of disease, rehabilitation to optimal levels of functioning and supportive measures for a dignified death.

2.02 GENERAL PROVISIONS

a. Standards of nursing practice will be implemented and monitored by each Nursing Service.

b. Registered nurses will be responsible for all nursing care. This will include the direct supervision of all categories of nursing personnel and nursing students.

c. Registered nurses will maintain competency in their nursing practice.

d. Patient care assignments will be specific and individualized according to the needs of patients and the qualifications of nursing personnel, and will provide continuity in care.

e. A registered nurse will be assigned to circulate and supervise nursing activities in each operating room during surgical procedures.

f. Registered nurses will exchange essential patient care information at the change of each tour of duty and at other times when appropriate. Relevant information will be shared among nurses, physicians, other direct care providers and the nursing administrative staff to ensure that patient care requirements are met. Registered nurses will be informed of channels of communication and lines of authority within the Nursing Service and the medical center.

g. The nursing staff will participate as members of the interdisciplinary health care team in planning, implementing, and evaluating patient care.

h. The nursing plan for care will maximize each patient's potential for self-care and independence. The patient and family will be included in planning nursing care and in setting goals.

i. Nursing care will be documented according to medical center policies and guidelines.

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2.03 PATIENTS' RIGHTS AND PATIENT ADVOCACY

a. Nursing personnel will provide care which is consistent with the patient's right to be treated with dignity in a humane environment that provides reasonable protection from harm and appropriate privacy. Nursing personnel will function in accordance with the VA Code of Patient Concern, the VA's published Patients' Rights, and other relevant policies and guidelines.

b. Prompt evaluation and appropriate intervention will be made in the event of a complaint, from any source, which is related to dissatisfaction with patient care.

c. Issues identified by a designated patient advocate will receive appropriate attention by Nursing Service personnel. Methods will be established to resolve issues related to patient care.

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d. Nursing Service personnel will report all incidents of alleged patient abuse, mistreatment, or neglect, by initiating a VA Form 10-2633, Report of Special Incident Involving a Beneficiary, in accordance with locally established reporting mechanisms.

2.04 QUALITY ASSURANCE

a. The Chief, Nursing Service, will be responsible for assuring that the evaluation of nursing practice is effectively accomplished; that nursing personnel are competent to function in their assignments; and, that action is taken to correct deficiencies. Optimal achievable standards of nursing practice will be promoted. Direct providers of nursing care will participate in the program. The Nursing Service quality assurance program will be integrated with the overall quality assurance program at the medical center. Findings which are obtained from the quality assurance review will be used to provide direction for planning appropriate nursing and staff development programs.

b. A CNPC (Clinical Nursing Practice Committee) will be established to improve the nursing care provided to veterans. Recommendations of the CNPC will be submitted to the Chief, Nursing Service, for decision making and action. Objectives of the CNPC will include the following:

(1) Assist in identifying nursing practice issues of concern throughout the medical center.

(2) Elicit input from nursing colleagues in the resolution of practice issues and in dealing with trends in health care and the nursing profession.

(3) Identify new techniques and creative approaches in nursing practice.

(4) Promote the application of relevant research in nursing practice, and

(5) Recommend methods of evaluating innovations in nursing practice.

2.05 LEGAL ACCOUNTABILITY

Nursing Service personnel will be responsible and accountable for providing care which conforms to usual and customary standards, and is within the limits of their own training and experience.

2.06 CLINICAL PRIVILEGES

a. A statement of clinical privileges will be established for registered nurses as necessary. This will be done in collaboration with nurse and physician supervisors before being forwarded to the appropriate local credentialing body for review. Final

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approval will be designated by the signatures of the Chief, Nursing Service, the supervising physician, Chief of Staff and the medical center Director.

b. Privileges are to be reviewed annually and may be amended, continued or suspended by following established procedures.

c. Routine nursing functions need not be designated in individual clinical privilege statements if they appear in the medical center's functional statements for registered nurses.

d. Nonroutine duties should be specified in clinical privilege statements according to the training and ability of the nurse, and the requirements of the practice setting to which the nurse is currently assigned.

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CHAPTER 4. EDUCATION IN NURSING SERVICE

4.01 STATEMENT OF POLICY

a. The educational program will assist staff members to develop the knowledge and skills necessary to provide effective patient care, and to fulfill organizational goals. The program will be consonant with current trends and concepts in health care and the nursing professional and standards of nursing practice.

b. Appropriate clinical experiences will be provided for nursing students in accordance with authorized affiliation agreements.

c. The Chief, Nursing Service, will designate a qualified registered nurse to establish, administer and evaluate the educational program.

d. Preceptorship training programs will be provided for key leadership positions in the Nursing Service in accordance with VA policies, guidelines, and the availability of funding.

4.02 GENERAL PROVISIONS

a. The educational program will be an integral part of the Nursing Service quality assurance program. Identified problems in nursing practice will be addressed by appropriate educational activities.

b. Educational activities will be an integral part of the Nursing Career Development Program to assist registered nurses in attaining knowledge, skills, and experience needed for positions of progressive responsibility and leadership.

c. Licensed practical/vocational nurses and nursing assistants will receive assistance in planning for career progression which will enhance their contributions and effectiveness in the care of veterans.

d. Sharing of educational resources available at other VA facilities will be encouraged when needs related to patient care programs cannot be met locally.

e. Requirements for the documentation of educational activities will be established by local policy and procedure.

f. Principles of safety for patients, employees and visitors will be incorporated into educational activities as appropriate.

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g. An orientation program will be provided for newly employed nursing personnel. Orientation will include instruction, supervision and guidance necessary to provide effective nursing care and to make a successful adjustment to the work environment.

h. Selected educational activities will be provided periodically on evening and night tours of duty.

i. Continuing education is the individual responsibility of registered nurses and licensed practical/vocational nurses. The purpose of continuing education will be to maintain currency in nursing practice through knowledge of trends and concepts in health care and the nursing profession.

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j. Staff members who provide direct patient care will contribute to the orientation/ educational program.

k. Selected joint appointments between schools of nursing and the Nursing Service will be encouraged for qualified personnel.

l. An educational program will be provided for nursing personnel assigned to special care units, such as intensive care and hemodialysis units.

m. The educational program will be reviewed and revised as appropriate to ensure effectiveness in improving nursing practice and meeting organizational goals.

4.03 MANDATORY TOPICS

Nursing personnel will receive information to assist them in meeting their responsibilities for maintaining a safe patient care environment. VA policies and procedures related to mandatory topics will be presented during the orientation program and thereafter to all nursing personnel in an annual review. Mandatory topics follow:

a. Safety and fire prevention

b. Patient evacuation and health mobilization during local and national disasters

c. Cardiopulmonary resuscitation

d. Management of an obstructed airway

e. Radiation safety

f. Infection control

g. Protective devices

h. Patient abuse/neglect

i. Disturbed behavior and suicide precautions

j. Administration of blood transfusions

k. Bioethics

l. Medical devices, and

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m. Others as locally identified to assure a safe environment.

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CHAPTER 5. RESEARCH IN NURSING SERVICE

5.01 STATEMENT OF POLICY

Research is basic to all components of nursing practice: clinical practice, administration and education. The objectives of the research program within Nursing Service will be as follows; (a) to generate new knowledge about patient care and the delivery system, and (b) to improve utilization of research findings.

5.02 GENERAL PROVISIONS

Nursing Service will promote a climate receptive to research activities. Nurses will apply appropriate research findings to their practice, and identify areas of practice that need to be studied. Nurses will be encouraged to initiate activities directed toward obtaining new knowledge and/or validating existing nursing practices. Encouragement will include assistance in obtaining consultation, in mobilizing resources, and in scheduling time needed to conduct research. Nurses who conduct research are expected to publish their findings. Nursing research will be carried out in accordance with all of the provisions of established VA policy and local Research and Development procedures.

5.03 SCOPE

The scope of research activities in nursing includes:

a. Studies related to current or proposed practices or procedures in clinical nursing, administration or education.

b. Studies related to patients' nursing needs, health or illness.

c. Studies to validate the findings from previous nursing studies.

d. Studies that are interdisciplinary or meet the criteria for cooperative/collaborative research, and which have direct implication for nursing.

e. Studies by nursing students as part of their educational program.

5.04 ROLE EXPECTATIONS

a. All nurses will apply appropriate and current research findings to their practice.

b. Nurses in clinical, administrative, and educational leadership positions will:

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(1) Obtain resources and consultations to assist nursing staff in developing scientifically meritorious research focused on the veteran patient and/or delivery system.

(2) Develop workshops, inservice education, etc., on utilization of current research findings.

c. Nurses whose major responsibility is the research program in Nursing Service will:

(1) Develop scientifically meritorious research focused on the veteran patient and/or the system for delivering care.

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(2) Explore a collaborative approach to conducting research.

(3) Expand research proposals to involve more than one VA medical center when appropriate.

(4) Consult with other nurses to increase the number of proposals submitted and resubmitted for merit review.

(5) Strengthen collaborative relationships with the scientific community.

(6) Consult with other nurses on the scientific merit of studies whose findings might be used in practice.

(7) Promote utilization of appropriate research findings.

5.05 MONITORING RESEARCH WITHIN NURSING SERVICE

The Chief, Nursing Service, will evaluate annually the quality and number of research studies being conducted by members of Nursing Service. The mechanism for reporting this evaluation will be the annual report. VA Central Office Nursing Service annually will examine and compare data from the annual reports and from RDIS (Research and Development Information System) to determine trends in the quality and quantity of research conducted by VA nurses.

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CHAPTER 6. VA CENTRAL OFFICE NURSING SERVICE REPORTING REQUIREMENTS

6.01 STATEMENT OF POLICY

Specified reports are required to maintain a coordinated Nursing Service and to facilitate the strategic management processes of Central Office Nursing Service.

6.02 GENERAL PROVISIONS

Nursing Service information will be forwarded within the facility as appropriate for computer entry in accordance with medical center policies and procedures.

6.03 REPORT OF QUALIFICATIONS OF NURSES, RCS 10-0016 (OLD RCS 10-147)

a. VA Form 10-5349, Professional Career Development Information (Physicians, Dentists and Nurses--Selected Positions) and VA Form 10-5349a, Professional Career Development Information (Nursing Supplement), will be completed annually by incumbents of centralized positions and nurses with a master's degree or higher degree. These forms will be updated throughout the year when career plans or qualifications change.

b. VA Form 10-5349a will be completed by all recipients of a VA Health Professional Scholarship at the time of appointment or upon completion of the scholarship program, and annually until obligated service is completed.

6.04 REPORT OF NURSING SERVICE, RCS 10-0034 (OLD RCS 10-220)

VA Forms 10-1106 and 10-1106a (AMIS), Nursing Service Code Sheet Manhours Worked by Nursing Personnel, will be prepared in accordance with VA policy and procedures.

6.05 NURSING SERVICE ANNUAL REPORT, RCS 10-0654 (PREVIOUSLY IDENTIFIED AS NURSING PROGRAM REPORT, RCS 10-0034 AND OLD RCS 10-220)

VA Form 10-9003, Nursing Service Annual Report, will be prepared annually as of September 30. It will provide information about the preceding fiscal year. The original and one copy will be forwarded through the appropriate Regional Director (10BA__/118) and is due in Central Office by the 10th workday in October.

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CLASSIFICATION OF PATIENTS ACCORDING TO THEIR NURSING CARE NEEDS

This appendix provides instructions for health care facilities to classify medical/surgical patients, extended care patients, critical care patients, psychiatric patients and spinal cord injury patients. The category in psychiatric patients excludes patients in drug and alcohol units. The methodologies are based on the classification of patients according to their nursing care requirements, related to patient dependency and amount of direct nursing care provided.

The purpose of the classification system is to determine the number of patients classified into each of several categories, depending on the clinical area, that represent requirements for nursing care and serve as a measure of staffing needs. (See MP-6, part VI, Supplement No. 1.2.) Each of the classification systems is briefly described below:

The Medical/Surgical Patient Classification System is used on Medical/Surgical Units. Spinal Cord Injury Units are excluded. This system classifies patients into four categories ranging from minimal nursing care (Category I) to more intensive nursing care (Category IV). VA Form 10-0005, Patient Classification Form, dated August 1981 is used to record information.

The Extended Care Patient Classification System is used on Intermediate Medicine and Nursing Home Care Units only. This classification system has three categories which range from minimal nursing care (Category I) to extensive/complete nursing care (Category III). Use VA Form 10-0005a, Nursing Patient Classification Form - Extended Care , dated May 1985.

The Critical Care Patient Classification System is used in critical care units only, i.e., Medical Intensive Care Units, Surgical Intensive Care Units, Coronary Care Units, and combinations of these. All other types of units are excluded. Specifically excluded are "step down" and "telemetry units." This classification system classifies patients into three categories which range from minimal nursing care (Category I) to extensive/complete nursing care (Category III). Use VA Form 10-0005b, Nursing Patient Classification Form - Critical Care , dated May 1985.

The Psychiatric Patient Classification System is used on Psychiatric Units only. Drug and Alcohol Units are excluded. This system classifies patients into four categories ranging from minimal nursing care (Category I) to extensive/complete nursing care (Category IV). Use VA Form 10-0005c, Nursing Psychiatric Patient Classification Form, dated January 1986.

[The Spinal Cord Injury Patient Classification System is used on Spinal Cord Injury Units only. This system classifies patients into five categories

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ranging from minimal nursing care (Category I) to extensive/critical (Category V). Use VA Form 10-0005d, Nursing Spinal Cord Injury Patient Classification Form, dated January 1989.]

These classification systems have been fully tested and validated. Instructions have been developed and effective application of the methodology will depend upon proper classification of the patient. A suggested procedure to ensure inter-rater reliability of 90 percent or better is described at the end of the appendix.

The Nursing Service of each medical center will classify patients daily. The appropriate patient classification form will be used for each patient depending on the clinical area. Patient identification information should be placed on the form and placed with the Nursing Care Plan (such as a Kardex). The patient will be assigned a category

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which best identifies individual nursing care needs using definitions provided for each classification system. Newly admitted patients will be classified upon admission. A registered nurse will classify assigned patients on a daily basis and the category of each patient will be verified at 3 p.m. every day by the head nurse or designee. After familiarity with the classification system, this procedure should be accomplished in a matter of seconds. The classifier should be a registered nurse who knows the patient. A second registered nurse should periodically sample and evaluate the classification process. Data should be reported according to the AMIS instructions.

INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005, PATIENT CLASSIFICATION FORM (MEDICAL/SURGICAL)

The following are a set of definitions and some examples of VA Form 10-0005. Categories range from I (minimal care) to IV (intensive care).

a. Patient identification information, unit, and date are entered at the top.

b. Clinical indicators are selected that appropriately describe the patient and marked by entering checks in all the horizontal white boxes/parentheses on the appropriate lines.

c. Add the checks in each column, downward. Preexisting fixed weight checks in columns I and II and the pre-weight of .5 in column III should be included in the count when adding the columns. Enter the sum of each column in the row marked "Total." The column with the highest total determines the patient's category. If the columns have the same total, the higher classification is noted. The appropriate category number at the top of the column is circled.

d. The "Comments" space is used to record a special situation which justifies a higher category than indicated by the total. For example, a patient in isolation, smoking hazard, or a wanderer.

e. The following definitions are to be used in completing the form:

Items Indicating Needs for Care	Definitions
(1) Activity Independent	Checked if patient takes own bath (basin at bedside, tub, or shower) with minimal supervision; manages own personal hygiene even if on maintenance IV, catheter, etc.; moves from bed without help. This item should not be checked if any of the following items (2) through (6) are checked.

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(2)	Bath, Partial Assist	Patient can start own bath, but not complete it. Needs help to get to shower or tub, and/or supervision and encouragement during bath. If patient needs help only to wash back, this item should not be checked; if patient requires complete bed bath, it should not be checked.
(3)	Position, Partial Assist	Patient can assist in turning or positioning in bed; cannot move independently from bed to chair. Needs help in maintaining proper alignment (e.g., traction, foot board).
(4)	Position, Complete Assist	Needs complete assistance in turning, position, and propping in bed or chair. This items also assumes patient cannot help with own bath. Only "Partial" or "Complete Assist" should be checked, not both.

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Items Indicating Needs for Care	Definitions
(5) Diet, Partial Assist	Can feed self after help in opening cartons, cutting meat, etc. May require supervision and encouragement to eat.
(6) Diet, Feed	Must be fed, or may need constant supervision and encouragement due to swallowing difficulty. Gastric gavage or gastrostomy tube feeding. Only "Partial Assist" or "Feed" should be checked, not both.
(7) IV additive every 6 hours	IV TKO (to be kept open) which requires frequent moni- or more, or IV to be kept open toring may be checked here even if patient is independently active.
(8) Observe every 1 to 2 hours	Requires symptom observation and monitoring over and above IV checks and every 2 to 4 hours vital signs, e.g., hourly output, 15-minute neurological checks, vital signs until stable after surgery or diagnostic procedure.
(9) Observe, Almost Constant	In addition to the above, requires almost constant observation due to special equipment, complex treatments and/or problems. Only one or the other of the"observe" items should be checked. If a patient requires constant observation, this fact, in most instances, will classify the patient as class IV regardless of the number of checks in each column.

The following are two case presentations used as examples:

Mr. S. 2/14/86
Soc. Sec. No 6W 62-4W

MEDICAL/SURGICAL--CASE NO. 1:

Mr. S., 63-year-old bilateral above the knee amputee, admitted to surgical unit with abdominal pain status post ileo resection with ileostomy and mucous fistula (Post-op day Number 6).

Vital signs q8h; daily weight. Requires close observation due to dehydration and weakness (at least q2-3h); is on a low sodium diet;

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requires constant encouragement to take fluids and nourishment; feeds self.

NS with Potassium via IV-requires close observation and frequent repositioning of arm to maintain rate and patency.

Up in chair-must be observed. Wet to dry abdominal dressing q8h.

Trach, ileostomy care; depressed and needs much encouragement.

Bathes self.

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Mr. J. 2/14/86
Soc. Sec. No. 2W, 216

MEDICAL/SURGICAL--CASE NO. 2:

Mr. J., 67-year-old patient on a medical unit with COPD and tracheostomy.

Unresponsive and requires total care.

VS q4h; I and O; turn q2h; water mattress; special skin care; up in chair q day;

Range of Motion tid.

External catheter; incontinent.

Tracheostomy care q8h with frequent suctioning (at least q1h); 26 percent 02 with mist via T-tube; Arterial/Blood gases qd.

Continuous tube feeding-check residual q8h.

Pilonidal cyst requires irrigation 1/2 strength peroxide q8h.

Continuous IV fluids; IV meds.

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INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005b, PATIENT CLASSIFICATION FORM - CRITICAL CARE

The following are a set of definitions and some examples of the Critical Care Patient Classification System. Categories include minimal care (I), moderate care (II), and extensive or complete care patients (III):

a. Patient information, unit, and date are entered at the top.

b. Clinical indicators are selected that appropriately describe the patient and marked by entering checks in parentheses on the appropriate lines. If the line has two sets of parentheses, these are both checked. The section labeled "Physiological Monitoring" requires one entry. If "Position Complete" is marked, the checks are placed in both sets of parentheses. The other patient care indicators are marked only as appropriate, e.g., if a patient is on room air and receiving no specific respiratory care, there would be no checks in the section labeled "Respiratory Status."

c. The number of checks in each column are totaled and entered on the appropriate lines. The fixed weight in Category II is to be included in the total.

d. The highest total of checks determines the patient category. If columns have the same total, the higher category is used. The appropriate category number at the top of the columns is circled.

e. The "Comments" space is used to record a special situation which justifies a higher category than indicated by the total. No explanation is needed for a Category III when "Special Procedures" is marked.

f. The following definitions are to be used in completing the form:

Items Indicating Needs for Care	**Definitions**
(1) Position	
(a) Partial Assist	Independent or needs partial assistance with ADL, coughing, and deep breathing.
(b) Complete Assist	Needs complete assistance with ADL and positioning, ROM, thermia units, special frames, circle beds, etc.
(2) Physiological Monitoring	

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At intervals of: More than 2 hours 1 to 2 hours 1 hour or less	Observation of body functions (temperature, blood pressure, heart function, etc.), including use of procedures or apparatuses for detecting and preventing problems.

(3) Intravenous Therapy

(a) IV	TKO; maintenance, Heparin lock; additive q4-6h.

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Items Indicating Needs for Care	Definitions
(b) IV--2 or more lines (Hemodynamic monitoring)	Multiple intravenous additivies; blood; hyper-alimentation; hemodynamic/pressure monitoring.
(4) Respiratory Status	
(a) Non-Acute	Oxygen therapy; few changes with ventilator settings; arterial lines; ventilator dependent; pulmonary toilet q4-q8h; treatments q4h.
(b) Acute	Weaning; frequent pulmonary toileting (ql-2h); frequent endotracheal suctioning; unstable respiratory status; intubation; frequent ventilator changes.
5) Special Procedures	These patients may require a 2:1 staff/patient ratio. May include such procedures as Blakemore tubes, cardioversion, insertion of pacemakers, intracranial pressure monitoring, extensive burn care, pericardiocentesis, circulatory or respiratory arrest, intra-aortic balloon pump, peritoneal dialysis, hemodialysis. A check on this line is automatically a Category III.

The following are three case presentations used as examples.

MICU--CASE NO. 1:

Mr. Brown, 58 years old, has been a patient in the MICU for the past 5 days and was admitted for Upper GI Bleeding. Bleeding was controlled with iced saline lavage and drug therapy. The patient also received multiple blood transfusions. Condition is now stable. Cardiac monitoring and IV has been discontinued; vital signs are taken every 4 hours. Mr. Brown needs assistance with all activities and will be transferred to a general medical unit this morning.

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SICU--CASE NO. 2:

Mr.Johnson was admitted to the SICU from the RR following a cholecystectomy. Patient had a myocardial infarction 8 months ago. During the operative procedure, Mr. Johnson had an episode of ventricular tachycardia with hypotension. The situation responded favorable to Lidocaine. The patient now has occasional PVC's. Vital signs are B/P 134/94, P-84 NSR, R-20. Mr. Johnson was extubated in the OR and is now on continuous O2 via face mask. A nasogastric tube and foley catheter are in place. Mr. Johnson's orders include vital signs and rhythm strips every hour. The patient has two peripheral IV's.

CCU--CASES NO. 3:

Mr. Jones age 58 was admitted to CCU with severe chest pain radiating to the left arm. Assessment revealed BP 90/60, AHR 58, Resp. 22. EKG showed an irregular heart rate. Skin was cool, clammy and diaphoretic. A Swan-Ganz catheter was inserted and PAWP and vital signs are monitored every 30 minutes. Two hours after admission, Mr. Jones' BP dropped to 60/? AHR 32. Vasopressors were started, IV and a demand pacer was inserted. Mr. Jones suffered acute respiratory failure, was intubated and placed on a ventilator. Mr. Jones' condition continues to deteriorate and preparations have begun for insertion of an IABP.

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INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005a, PATIENT CLASSIFICATION FORM - EXTENDED CARE

The following are a set of definitions and some examples of the Extended Care Patient Classification System. Categories range from minimal nursing care (I) to extensive/complete nursing care (III):

a. Patient information, unit, and date are entered at the top.

b. Items in each of the five major areas are checked that best describes the patient's needs. Only one item should be checked for each major care area. For example, if in the area of basic hygiene, a patient needs to be bathed completely by nursing staff, "Complete Assist" is checked.

c. The number of checks in each column are added vertically and then entered in the row marked "Total" under the appropriate column. The column with the greatest number of checks is the patient's classification.

d. The appropriate category should be circled at the bottom of the form. If there is a tie, the higher category is circled.

e. The following definitions are to be used in completing the form:

Areas Indicating Needs for Care	**Definitions**
(1) **Basic Hygiene/Bathing**	
(a) Self	Patient needs no help or supervision.
(b) Partial Assist	Patient can start own bath but cannot complete it. May need help to get into shower or tub, supervision or encouragement during bath, or assistance to dress.
(c) Complete Assist	Must be bathed, showered and dressed (does not participate).
(2) **Nutrition/ Feeding**	
(a) Self	Patient needs no help or supervision.
(b) Partial Assist	Can feed self after cartons are opened and food is cut. May require supervision and encouragement to eat.

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(c) Complete Assist	Must be fed totally by another person; or may need constant supervision and encouragement due to swallowing difficulties, resistiveness. Include gastric gavage; tube feedings.

(3) **Elimination**

(a) Self	Patient is continent and does not have accidents or takes care of ostomy, catheter, or related device by self.

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Areas Indicating Needs for Care	Definitions
(b) Assist	Requires assistance with bedpan or urinal; or receives help in care of ostomy, catheter or related device. May include a scheduled bowel or bladder program.
(c) Incontinent	Has inadequate control of bladder or bowels (regardless of staff intervention) requiring complete assistance/incontinent care at least once per shift.
(4) **Mobility**	
(a) Self	Patient transfers, walks or wheels self without assistance or supervision.
(b) Partial Assist	Needs some assistance or supervision in transferring, walking or wheeling.
(c) Complete Assist	Needs complete assistance (does not participate) in transferring; is wheeled or bed confined. Requires help in positioning and maintaining proper alignment (i.e., traction, footboards).
(5) **Behavior/Orientation**	
(a) Alert, Oriented, Responsive	Patient is oriented to time, place, person. No disruptive behavior problems.
(b) Occasionally Disoriented, Confused	Disoriented in one or two spheres (time, place, person); may have alternative periods of awareness/unawareness; may exhibit some disruptive behavior, i.e., disrobing, screaming, wandering into unacceptable places.
(c) Disoriented, Combative, Unresponsive	Is disoriented in all three spheres (time, place, person), or is unresponsive or exhibits resistive, striking out, or aggressive behavior to a degree that there is impairment in the performance of basic activities of daily living.

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The following are two case presentations used as examples:

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EXTENDED CARE--CASE NO. 1:

Mr. G. is an 80-year-old male with post partial bowel resection 2 months and a secondary diagnosis of degenerative joint disease. Bowel sounds are present and patient tolerates regular diet well. Due to limited ROM, Mr. G. needs assistance with setting up food tray, bathing and dressing. Mr. G. ambulates with a walker and maintains bathroom privileges with assistance. Mr. G. ambulates TID, is up in a chair for 1 hour TID, and has VS q8h.

EXTENDED CARE--CASE NO. 2:

Ms. M. is a 72-year-old female admitted for a right pelvic fracture which occurred 4 months ago. Ms. M. was transferred from the surgical unit. Secondary diagnoses include insulin controlled diabetes mellitus, hypertension and arthritis. Patient is blind and has some loss of hearing and is edentulous, and cannot tolerate oral intake. Continual enteral nutrition support via Keofeed tube is needed to prevent further weight loss. Due to pelvic immobilization, arthritis, and generalized weakness, Ms. M. requires complete assistance with ADL's. Patient experiences transient disorientation at night which requires placement of protective devices.

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INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005c, NURSING PSYCHIATRIC PATIENT CLASSIFICATION FORM

The following are a set of definitions and some examples of VA Form 10-0005c categories ranging from minimal care (I) to extensive nursing care (IV).

a. Patient identification information, unit, and date are entered at top of form.

b. Patient care indicators are marked by entering checks in parentheses on appropriate lines. If the line has multiple parentheses, check them all.

c. The indicator that best describes the patients care needs is checked in each of the five major areas. Only one indicator should be checked for each major care area. For example: Unit Privileges--if a patient may leave the unit alone, only this indicator should be checked. When checking an indicator, all brackets [ ] must be checked horizontally for that indicator.

d. The number of checks in each column is totaled and entered on the appropriate lines. Always include the fixed weight count in Categories I, II, and III.

e. The column with the highest total determines the patient's category. The appropriate category number at the top of the column is circled.

f. The "Comments" space is used to record a special situation which justifies a higher category than indicated by the total. For example, a patient requiring complex dressings.

g. The following definitions are to be used in completing the form.

Areas Indicating Needs for Care	**Definitions**
(1) Observation/Intervention	
(a) Routine	Requires observation of specific symptoms or conditions (b) 15-25 Min/Hr. that would require nursing to observe patient over and (c) 30-45 Min/Hr. above routine rounds. Includes vital signs, neuro checks, (d) Constant color, patient orientation and/or combativeness. The appropriate criteria should be checked according to the time listed. Also included in the criterion is the amount of time required on an interpersonal level.

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(2) Unit Privileges

(a) May leave unit alone	Check, if patient has a pass or permission to leave unit unaccompanied.
(b) Out with staff/family	Check, if patient has off unit privileges with family, staff members or others.
(c) Restricted to unit	Check, if patient has no pass or is not allowed off unit to attend groups.
(d) Restricted to room	Check, if patient is restricted to room or is in seclusion.

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Areas Indicating Needs for Care	Definitions
(3) Restraint Application	
(a) No	Check yes, for patient who requires application of leather/plastic restraints.
(b) Yes	Check no, if it does not apply.
(4) Incontinent of Bowel/Bladder	
(a) No	Check yes, for patient who is actively incontinent of urine or feces. Also applies to patients with extreme diaphoresis. Does not need to be marked if patient has indwelling catheter.
(b) Yes	Check no, if it does not apply.
(5) One to One Restriction	
(a) No	Check yes, if patient requires constant nursing supervision during the entire shift, (e.g., suicide precautions).
(b) Yes	Check no, if it does not apply.

The following are three case presentations used as examples.

PSYCHIATRIC--CASE NO. 1:

Mr. J., 47 years old, was admitted 2 weeks ago with Post-traumatic Stress Disorder. Patient has been attending group therapy on a daily basis. Mr.J. needs minimal supervision from the nursing staff and is motivated to follow treatment plan. Mr. J. is involved with Social Service for job retraining and placement.

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PSYCHIATRIC--CASE NO. 2:

Mr. P. is a 52-year-old who was admitted with a diagnosis of Undifferentiated Schizophrenia. He is hospitalized for medication reevaluation. He attends unit activities and is fairly cooperative. At times, is delusional in conversations with peers and staff. Patient is only allowed to go off the unit with a staff or family member.

PSYCHIATRIC--CASE NO. 3:

Mr. S., 76 years old, was admitted 2 days ago with a diagnosis of Alzheimer's Disease. Patient is disoriented x3. Mr. S. requires complete assistance with ADL's and is incontinent of urine. Nursing staff interact frequently with Mr. S., for reality orientation. Patient is restricted to the unit as Mr. S. wanders and gets lost.

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SUGGESTED PROCEDURE TO ENSURE INTER-RATER RELIABILITY AMONG NURSES IN CLASSIFYING PATIENTS USING VA PATIENT CLASSIFICATION METHODOLOGIES

Why Is Inter-Rater Reliability Important?

The determination of workload and nurse staffing requirements are dependent on accurate classification of patients. Inter-rater reliability is a method to establish and maintain consistency in the way nurses classify patients both within an individual nursing unit and among all similar units at each medical center.

In order to check on the internal consistency of the patient classification system, an evaluation of inter-rater reliability must be conducted. Since accurate assessments of patient classification are an integral component in the determination of required nursing hours, the reliability of the patient classification process should be evaluated periodically and corrective measures should be taken when indicated as part of an ongoing program.

Purpose and Scope.

The purpose of this procedure is to measure and minimize variability in the way different nurse raters classify the same kinds of patients using a VA patient classification system. The procedure is directed at achieving a high level of consistency in patient classification or inter-rater reliability within a health care facility. Efforts to measure and attain high inter-rater reliability among different medical centers within the VA health care system may be taken at a later date.

Who Should Perform This Function?

The success of the patient classification system and the evaluation of inter-rater reliability is dependent upon knowledge of the system and a commitment to it by each nurse who is involved. A registered nurse, designated by the Chief, Nursing Service, should be assigned the overall responsibility to evaluate levels of inter-rater reliability. The nurse assigned this responsibility may be in either a staff role or a management position. This determination should be based on the organization structure of the Nursing Service and availability of resources. Nurses who should be considered are Nursing Instructors, Clinical Nurse Specialists, Nursing Supervisors, and Head Nurses.

Two additional nurses, designated by the Chief, Nursing Service, should be assigned to assist the nurse who is responsible for this project. Assistants should have a thorough knowledge and demonstrate competence in the nursing care requirements of patients in a selected area and in the patient classification

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system. These nurses should also demonstrate consistency in the manner in which they classify patients.

Process

This approach is based on evaluating the consistency of patient classification among nurses, and working with individual nursing units until acceptable levels of consistency are achieved. A reduced frequency of review is then performed to ensure continued high levels of reliable patient classification.

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The proposed frequency and scope for evaluating consistency is outlined below:

a. Concentrate efforts to achieve acceptable consistency on one unit at a time. Work with that unit only until the goal of 90 percent consistency is reached, then move to the next unit.

b. The evaluating nurses should classify 15 patients on the nursing unit every day until 90 percent consistency is achieved. Consistency, in this instance, will mean that nurses on the unit are following the established procedure for classifying patients, and that there is agreement between the evaluating nurse and the unit nurses in the classification assigned to each patient.

c. The evaluating nurse should classify patients without prior consultation with nurses on the unit.

d. Corrective measures should be taken immediately after an evaluation when consistency is found to be less than 90 percent. This should be done in a helpful and instructive manner with the nursing unit staff. Immediate feedback to the Head Nurse is recommended. The participation of the Head Nurse is essential in efforts to clarify points of confusion and to achieve greater consistency.

e. After a unit has achieved 90 percent consistency, plan to evaluate it again at the end of 1 month to ensure that 90 percent consistency is maintained. If classification consistency falls below 90 percent, continue a more intensive review until problems are corrected.

f. When a nursing unit has maintained 90 percent consistency at the end-of-month review, plan to review the unit every 3 months thereafter.

g. Nursing unit personnel should not know in advance when a review is to be performed.

Guidelines To Aid Reviewer:

(a) A data collection form should be prepared which contains 10 sample patient classification cards on an 8 1/2 x 11 sheet of paper.

(b) Each nurse reviewer will be assigned to a specific unit. To maintain objectivity the reviewer should not be assigned to their own unit.

(c) The reviewer will independently classify patients. This process may include:

Review of the nursing care plan

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Review of the patient's chart

Direct patient observation

(d) Continue until all 15 patients have been classified.

(e) Compare patient classification results obtained through the independent review with the results of the same 15 patients classified by the unit. In reviewing the unit's classification results, it is important to check the accuracy and completeness of the classification forms done by the individual unit. This includes checks on addition and correct procedures in marking the form.

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(f) Identify inconsistencies between results of the classification done on the unit and the reviewer's results on the data collection form. Discuss these with the Head Nurse or Nurse in Charge.

(g) Provide further comments on the data collection sheet, as appropriate for each discrepancy, noting whether the variation is justified based on additional information or is considered to be unjustified.

(h) Results should be entered on a summary report for each unit. A sample report illustrating the format is shown:

Inter-Rater Reliability Summary Report

Psychiatric Patient Classification System

		Number of Classifications		**Percentage**
Unit	Date of Review	With Agreement	Without Agreement	of Consistency
4A	2/15/86	12	3	80

Comments:

Example: 15 patients were reviewed and classified. There was inter-rate agreement on 12 patients. Therefore, the percentage of consistency was 12 divided 15, which is 80 percent.

Results of the reviews provide a valuable management tool in directing educational and other resources to areas where problems may exist. This information also provides a method to determine the status of the implementation of the patient classification system and the reliability of the data within each Nursing Service.

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INSTRUCTIONS AND DEFINITIONS FOR VA FORM 10-0005d, NURSING SPINAL CORD INJURY PATIENT CLASSIFICATION FORM

The following are a set of definitions and some examples of VA Form 10-0005d (categories range from I (Minimal Care) to V (Extensive/Critical)):

a. The patient's name, bed number, unit and date are entered at the top of the form.

b. Those items/factors which best describe a given patient are checked in all columns in the corresponding row for the items. For example, if Bowel Care, Complete Assist, is marked, you should have checks in the brackets in columns three and four.

c. If you check Activity Independent, you must not check any other indicator.

d. Only one of the monitor categories may be checked.

e. If you check any of the monitor/observe/teach indicators there must be some type of intervention being done for the patient in the time frames indicated.

f. Total the number of checks in each column and enter the totals on the appropriate lines. Always include the FIXED WEIGHT count in Categories I, II, and III. The category should be circled at the top of the form.

g. The column with the highest total determines the patient's category. The appropriate category number at the top of the column is circled. Should a tie occur the patient should receive the higher category.

h. Use the "Comments" space to record a special situation which justifies a higher category than indicated by the total. For example, a patient requiring strict isolation.

i. A check in column five under constant monitoring will automatically make the patient a Category 5.

j. The following definitions are to be used in completing the form.

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AREAS INDICATING NEEDS FOR CARE

DEFINITIONS

1. **ACTIVITY, INDEPENDENT**	Checked if patient takes own bath/shower at bedside or bathroom. Must transfer self without help. This item should not be checked if any of the following items, number (2) through (9), are checked.
2. **BATH/SHOWER**-Set-up, Stand by or Partial Assist	Patient can begin own bath after set-up. Needs help to get to shower or tub, and supervision and encouragement during bath. May need some verbal cues and either stand by or partial assist. Do not check if needs total bath with complete assist.
3. **BATH/SHOWER** Complete Assist	Is dependent in bathing/showering or the patient may require so much guidance and cues that the bath/shower requires as much time as a complete assist. Do not check both (2) and (3).
4. **POSITION/TRANSFER** Set-up, Stand by or Partial Assist	Patient cannot move independently from bed to wheelchair or toilet but can assist with positioning /transferring. Patient may be able to do activity after set-up of chair, bed, etc. Will need help with proper alignment after positioning or transferring.
5. **POSITIONING/TRANSFER** Complete Assist	Is dependent in transferring/positioning or the patient may require so much guidance and cues that the positioning/transferring requires as much time as a complete assist. Do or not check both (4) and (5).
6. **DIET**-Set-up Stand by or Partial Assist	Patient must be set-up for meals either with of adaptive devices or without them, must be supervised through the meal or must require partial assistance in eating.

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7.	**DIET-**Complete Assist	Patient must be assisted with most of diet or is totalling dependent in eating.
8.	**BOWEL CARE** Set-up, Stand by or Partial Assist	Patient must require assistance in establishing a bowel care program and in carrying out the activities of the program, either by set-up or stand by.
9.	**BOWEL CARE** Complete Assist	Patient requires assistantce in most of the tasks around the bowl care program and cannot consistently assist with own program
10.	**MONITOR/OBSERVE/** TEACH 15-25 Min./Hr.	Patient requires nursing intervention with teaching, monitoring and/or observing for 15-25 minutes per hour.

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11. **MONITOR/OBSERVE/TEACH** 30-45 Min./Hr.	Patient requires nursing intervention with teaching, monitoring and/or observing for 30-45 minutes per hour.
12. **CONSTANT MONITORING**	Patient requires constant monitoring or interventions because of special equipment or medical problems. (i.e., 1:1 staffing).

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The following are case presentations used as examples.

EXAMPLE 1

Mr. Smith is a 50 year old veteran with an incomplete injury of L5. Mr. Smith returned to the facility for his yearly checkup. Mr. Smith is able to do all activities of daily living and transfer. Mr. Smith needs minimal emotional support and teaching.

NURSING
SPINAL CORD INJURY
PATIENT CLASSIFICATION FORM

NAME Mr. Smith UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
ACTIVITY, INDEPENDENT	(X)				
BATH/SHOWER-Set-up, Stand by or Partial Assist		( )	( )		
BATH/SHOWER-Complete Assist			( )	( )	
POSITION/TRANSFER-Set-up, Stand by or Partial Assist		( )	( )		
POSITION/TRANSFER Complete Assist			( )	( )	
DIET-Set-up, Stand by or Partial Assist		( )	( )		
DIET-Complete Assist			( )	( )	
BOWEL CARE-Set-up, Stand by or Partial Assist		( )	( )		
BOWEL CARE-Complete Assist			( )	( )	
MONITOR/OBSERVE/TEACH 15-25 Min/Hr.			( )	( )	
MONITOR/OBSERVE/TEACH 30-45 Min/Hr.				( )	

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CONSTANT MONITORING ( )

FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	2	1	.5	0	0

COMMENTS

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EXAMPLE 2

Mrs. Smith, a 48 year old patient with a fracture of C5-6, has returned to the facility because of a urinary tract infection. Mrs. Smith is able to shower unassisted but needs assistance in setting up the equipment for bowel care and meals. Mrs. Smith has been placed on antibiotics and is undergoing further bladder function exams.

NURSING
SPINAL CORD INJURY
PATIENT CLASSIFICATION FORM

NAME Mrs. Smith UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
ACTIVITY, INDEPENDENT	( )				
BATH/SHOWER-Set-up, Stand by or Partial Assist		( )	( )		
BATH/SHOWER-Complete Assist			( )	( )	
POSITION/TRANSFER-Set-up, Stand by or Partial Assist		( )	( )		
POSITION/TRANSFER Complete Assist			( )	( )	
DIET-Set-up, Stand by or Partial Assist		(X)	(X)		
DIET-Complete Assist			( )	( )	
BOWEL CARE-Set-up, Stand by or Partial Assist		(X)	(X)		
BOWEL CARE-Complete Assist			( )	( )	
MONITOR/OBSERVE/TEACH 15-25 Min/Hr.			( )	( )	
MONITOR/OBSERVE/TEACH 30-45 Min/Hr.				( )	

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CONSTANT MONITORING ( )

FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	3	2.5	0	0

COMMENTS

VA FORM 10-0005d

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EXAMPLE 3

Mr. Jackson is a 33 year old veteran with a C3-4 fracture who was injured in an automobile accident. Mr. Jackson needs complete assistance with transfer and bowel care. Mr. Jackson has an IV with multiple additives. The monitoring of IV's and multiple additives plus teaching requires the staff to spend 15 minutes per hour with Mr. Jackson.

NURSING
SPINAL CORD INJURY
PATIENT CLASSIFICATION FORM

NAME Mr. Jackson UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
ACTIVITY, INDEPENDENT	( )				
BATH/SHOWER-Set-up, Stand by or Partial Assist		( )	( )		
BATH/SHOWER-Complete Assist			( )	( )	
POSITION/TRANSFER-Set-up, Stand by or Partial Assist		( )	( )		
POSITION/TRANSFER Complete Assist			(X)	(X)	
DIET-Set-up, Stand by or Partial Assist		( )	( )		
DIET-Complete Assist			( )	( )	
BOWEL CARE-Set-up, Stand by or Partial Assist		( )	( )		
BOWEL CARE-Complete Assist			(X)	(X)	
MONITOR/OBSERVE/TEACH 15-25 Min/Hr.			(X)	(X)	
MONITOR/OBSERVE/TEACH 30-45 Min/Hr.				( )	

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CONSTANT MONITORING ( )

FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	1	3.5	3	0

COMMENTS

VA FORM 10-0005d

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EXAMPLE 4

Mr. Peters, a 20 year old veteran with a C3-4 fracture, was admitted 2 months ago following a diving accident. Mr. Peters is experiencing severe emotional trauma due to his injury. Mr. Peters needs complete assistance with activities of daily living, meals and bowel care. Recently weaned from a respirator, Mr. Peters needs two, 10-minute respiratory assessment per hour. Mr. Peters is very hostile and abusive to staff and requires at least three, 5-minute staff interactions per hour.

NURSING
SPINAL CORD INJURY
PATIENT CLASSIFICATION FORM

NAME Mr. Peters UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
ACTIVITY, INDEPENDENT	( )				
BATH/SHOWER-Set-up, Stand by or Partial Assist		( )	( )		
BATH/SHOWER-Complete Assist			(X)	(X)	
POSITION/TRANSFER-Set-up, Stand by or Partial Assist		( )	( )		
POSITION/TRANSFER Complete Assist			(X)	(X)	
DIET-Set-up, Stand by or Partial Assist		( )	( )		
DIET-Complete Assist			(X)	(X)	
BOWEL CARE-Set-up, Stand by or Partial Assist		( )	( )		
BOWEL CARE-Complete Assist			(X)	(X)	
MONITOR/OBSERVE/TEACH 15-25 Min/Hr.			( )	( )	

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MONITOR/OBSERVE/TEACH
30-45 Min/Hr. (X)

CONSTANT MONITORING ( )

FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	1	4.5	5	0

COMMENTS

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EXAMPLE 5

Mr. Vicarelli is a 25 year old male with a fractured T4 who was injured in a motorcycle accident. Mr. Vicarelli was transferred to this facility on a respirator due to a pneumothorax. Mr. Vicarelli has one chest tube and multiple rib factures. Mr. Vicarelli has IV's with multiple additives and must be turned every hour due to large decubitus ulcers on his coccyx. Due to excessive bronchial secretions, Mr. Vicarelli must be suctioned for 40 minutes per hour. Mr. Vicarelli is on hyperalimentation. Hourly outputs are being measured to assess kidney function. 1:1 staffing is required due to the monitoring and interventions needed by Mr. Vicarelli.

NURSING
SPINAL CORD INJURY
PATIENT CLASSIFICATION FORM

NAME Mr. Vicarelli UNIT 1-A DATE 10/1/87

PATIENT CLASSIFICATION	I	II	III	IV	V
ACTIVITY, INDEPENDENT	( )				
BATH/SHOWER-Set-up, Stand by or Partial Assist		( )	( )		
BATH/SHOWER-Complete Assist			( )	( )	
POSITION/TRANSFER-Set-up, Stand by or Partial Assist		( )	( )		
POSITION/TRANSFER Complete Assist			(X)	(X)	
DIET-Set-up, Stand by or Partial Assist		( )	( )		
DIET-Complete Assist			(X)	(X)	
BOWEL CARE-Set-up, Stand by or Partial Assist		( )	( )		
BOWEL CARE-Complete Assist			(X)	(X)	
MONITOR/OBSERVE/TEACH 15-25 Min/Hr.			( )	( )	

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MONITOR/OBSERVE/TEACH
30-45 Min/Hr. ( )

CONSTANT MONITORING (X)

FIXED WEIGHTS	(X)	(X)	.5		
TOTAL	1	1	3.5	3	1

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